Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____Sex____Marital Status_____Date of Birth_____
Address_____City_____State_____Zip_____Phone_____
Social Sec. #_____Who referred you to our office?_____
Occupation_____Work Phone_____Company & Location_____
Spouse's Name_____Spouse S.S.#_____
Spouse's Employer_____Location_____
Please explain in detail how your accident happened_____
_____
_____
_____
Name of Driver of other vehicle_____Ins Phone_____
Insurance Co_____Policy No_____Claim No_____

Driver of your vehicle_____Your Ins. Phone_____
Insurance Co_____Policy No_____Claim No_____
Have you retained an attorney? ___Yes ____No
If so, his name and phone_____
You were heading ___North ___East ___South ___West on_____St.
Other vehicle was headed ___North ___East ___South ___West on _____St.
Were police notified? ___Yes ___No
Were you knocked unconscious? ___Yes ___No If so, for how long?_____
You were struck from __Behind __Front __Left Side __Right Side
You were__Driver __Passenger __Front seat __Back seat __Using Seatbelts __Other
What were the time and date of accident?_____
Where did you feel pain immediately after the accident?_____
Where were you taken after the accident?_____
What treatment was given?_____
Was any other doctor consulted after your accident? ___Yes ___No
If so, what was the doctor's name?_____ __DC, __MD, __DO, __DDS
What was the diagnosis?_____
What treatment was given?_____
How often did you see the doctor?_____
How long did you see the doctor?_____
Have you ever had any complaints in the involved area before? ___Yes ___No
If so, what were the complaints?_____
Were you capable of working well with others your age before accident? __Y __N
Are work activities restricted as a result of this accident? __Yes __No
Since this injury are your symptoms ___Improving? ___Getting Worse? ___Same?

Health Questionnaire:

Please place a check next to the symptoms you presently have.

MUSCULO-SKELETAL SYSTEM

___Low back problems
___Pain between Shoulders
___Neck problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Weak muscles
___Walking Problems
___Ruptures
___Broken bones

GENITO-UNIARY SYSTEM

___Bladder trouble
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE

___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast

Are you pregnant?
___Yes ___No

GASTRO-INTESTINAL SYSTEM

___Poor appetite
___Excessive hunger
___Difficult chewing
___Difficult swallowing
___Excessive thirst
___Nausea
___Vomiting food
___Vomiting blood
___Diarrhea
___Constipation
___Black stool
___Hemorrhoids
___Liver trouble
___Gall bladder
___Weight trouble

NERVOUS SYSTEMS

___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid hearbeat
___Blood pressure problems
___Heart problems
___Lung problems
___Varicose veins

EYE, EAR, NOSE, AND THROAT

___Eye strain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nose bleeding
___Nose discharge
___Difficult breathing thru nose
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Hoarseness
___Difficult speech

_____

PATIENT'S SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE